Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: VISTA MEDICAL CENTER HOSPITAL 4301 VISTA ROAD PASADENA TX 77504	MFDR Tracking #: M4-04-3911-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ACIG INSURANCE CO Box #: 47	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Medical Center Hospital charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum of 70% of billed charges. This is supported by the Focus managed care contract. This managed care contract supports Vista Medical Center Hospital's argument that the usual and customary charges are fair and reasonable and **at the very minimum**, 70% of the usual and customary charges is fair and reasonable…the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for Ambulatory Surgical Centers medical services." "…amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, TWCC stated specifically that managed care contracts are fulfill the requirements of Texas Labor Code Section 413.011 as they are 'relevant to what fair and reasonable reimbursement is,' they are relevant to achieving cost control,' they are relevant to ensuring access to quality care,' and they are 'highly reliable.' See 22 TexReg 6272. Finally, managed care contracts were determined by the TWCC to be the best indication of a market price voluntarily negotiated for medical services."

Amount in Dispute: $69,618.10

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Carrier's rate of reimbursement in this case meets the Act's criteria for payment. Vista has the burden of proof in this case. As stated by the MRD in numerous prior ASC disputes, 'regardless of the carrier's application of its methodology, lack of methodology, or response, the burden is on Vista to show that the amount of reimbursement requested is fair and reasonable'…The Vista has not met its burden of proof under rule 133.307(g)(3)(D) to establish that reimbursement of its billed charges of $70,718.10 meets the statutory standards under the Act for reimbursement of outpatient hospital facility services for a shoulder arthroscopy. On the contrary, this amount is grossly excessive as established by the Commission's inpatient surgical per diem rate; the Medicare rate; and finally, the proposed rate under the outpatient hospital facility fee guideline being drafted by the Commission. For these reasons, Vista has not met its burden of proof to establish that its charges comply with the Act's statutory standards for reimbursement and that Carrier's rate of payment of does not."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
12/10/2002	None Listed	Outpatient Services	$69,618.10	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on November 24, 2003. Pursuant to Division

rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 2, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment without any reason code(s) listed. The requestor states in the letter requesting reconsideration that "…the Carrier did not provide an EOB, only a check-stub as evidence of 'final action.'"
2. Division rule at 28 TAC §134.401(a)(4), effective August 1, 1997, states "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements."
3. This dispute relates to services with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative/recovery record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(B).
6. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
7. Division rule at 28 TAC §133.307(g)(3)(E), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to "Prior to submission, any documentation that contains confidential information regarding a person other than the injured employee for that claim or a party in the dispute must be redacted by the party submitting the documentation, to protect the confidential information and the privacy of the individual. Un-redacted information or evidence shall not be considered in resolving the medical fee dispute." Review of the documentation submitted by the requestor finds that the requestor has submitted unredacted confidential information regarding a person other than the injured employee. Therefore, the requestor has failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(g)(3)(E).
8. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position summary states that "Vista Medical Center Hospital charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services."
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline, 22* TexReg 6276 (July 4, 1997). It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 TexReg 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable

reimbursement for the services in dispute.

- In the alternative, the requestor asks to be reimbursed a minimum of 70% of billed charges, in support of which the requestor states that "The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum of 70% of billed charges. This is supported by the Focus managed care contract. This managed care contract supports Vista Medical Center Hospital's argument that the usual and customary charges are fair and reasonable and **at the very minimum**, 70% of the usual and customary charges is fair and reasonable…the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for Ambulatory Surgical Centers medical services."
- Texas Government Code § 2001.081 states that "The rules of evidence as applied in a nonjury civil case in a district court of this state shall apply to a contested case…" The Texas Rules of Evidence, Rule 1002 requires that "To prove the content of a writing, recording, or photograph, the original writing, recording, or photograph is required except as otherwise provided in these rules or by law." Review of the requestor's documentation finds that the requestor did not submit a copy of the alleged contract for consideration, nor did the requestor demonstrate that any exception to this requirement applies to the documentation in this dispute.
- The requestor has provided select exhibit pages from the alleged managed care contract referenced above, however a copy of the contract referenced in the position statement was not presented for review with this dispute.
- Review of the exhibit pages submitted by the carrier finds that the fee schedule page (labeled exhibit A) dated effective August 1, 1992 states, in part, that the provider shall receive "an amount equal to eighty percent (80%) of the Usual and Reasonable Charge for those Covered Services." It goes on to define the Usual and Reasonable Charge as "equal to the lesser of: (i) the actual charges billed by HCP for such services; or (ii) the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research database."
- No data or information was submitted from the Medical Data Research database to support the requested reimbursement.
- The requestor also presented a separate schedule of charges (also labeled exhibit "A") dated 04/23/92, which states that "OUTPATIENT SERVICES: 101/401 PAY 70% OF BILLED CHARGES", however this exhibit page is dated before the August 1, 1992 exhibit page referenced above, which specifies a different reimbursement amount.
- No evidence was presented by the requestor to support that the referenced contract was in effect at the time of the disputed services.
- The requestor's position statement further asserts that "amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, TWCC stated specifically that managed care contracts are fulfill the requirements of Texas Labor Code Section 413.011 as they are 'relevant to what fair and reasonable reimbursement is,' they are relevant to achieving cost control,' they are relevant to ensuring access to quality care,' and they are 'highly reliable.' See 22 TexReg 6272. Finally, managed care contracts were determined by the TWCC to be the best indication of a market price voluntarily negotiated for medical services…"
- While managed care contracts are relevant to determining a fair and reasonable reimbursement, the Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 Texas Register 6276 (July 4, 1997) that:

  > "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

- The requestor did not discuss or explain how payment of $69,618.10 would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

9. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(B), §133.307(g)(3)(C), §133.307(g)(3)(D), and §133.307(g)(3)(E). The Division

further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

		4/20/2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		4/20/2011
Authorized Signature	Health Care Business Management Director	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.